Whenever two people meet there are really six people present. There is each man as he sees himself, each man as the other person sees him, and each man as he really is.

William James

The psychodynamic assessment of a patient does not stand apart from the thorough evaluation of history, signs, and symptoms growing out of the medical-psychiatric tradition. Dynamic psychiatrists value such information as a crucial component of the diagnostic assessment. However, their approach to gathering that information differs from the purely descriptive approach to diagnosis. Moreover, other information is of interest to the dynamic psychiatrist, so the psychodynamic assessment may be viewed as a significant extension of the descriptive medical-psychiatric evaluation.

The Clinical Interview

Any description of the psychodynamic approach to clinical interviewing must begin with the fundamental importance of the doctor–patient relation-
ship. When psychiatrist and patient meet for the first time, two strangers are coming into contact, each with a variety of expectations concerning the other. Establishing rapport and a shared understanding must always be the first agenda in a psychodynamic interview (MacKinnon et al. 2006; Menninger et al. 1962; Thomä and Kächele 1987). The first task of the interviewer, then, is to convey that the patient is accepted, valued, and validated as a unique person with unique problems.

Interviewers who attempt to immerse themselves empathically in their patients’ experience will promote a bond between them based on the interviewer’s obvious attempt to understand the patient’s point of view. Such an approach does not require reassuring comments such as “Don’t worry, everything will be all right.” Rather than allaying the patient’s anxiety, these hollow reassurances are usually doomed to failure because they resemble similar past comments of friends and family members. They will only lead the patient to believe that the interviewer does not appreciate true suffering. Interviewers may instead build better rapport with comments such as “I can understand how you feel, considering what you’ve been through.” Challenging a patient’s statements early in the interview will simply confirm any pre-existing fears that psychiatrists are judgmental parental figures.

Differences Between Psychodynamic and Medical Interviewing

In medical interviewing, physicians pursue a direct course from the chief complaint to its etiology and pathogenesis. Patients generally cooperate with this process because they are eager to eliminate the pain or symptoms associated with their illness. Psychiatrists who attempt to steer a similarly linear course in the clinical interview will encounter potholes and detours at every turn. Moreover, psychiatrists find that patients rarely are capable of coming quickly to the point because of their inability to pinpoint what is really bothering them (Menninger et al. 1962). They may also be highly ambivalent about giving up their symptoms because psychiatric illness is somehow always a workable adaptation. Finally, psychiatric patients are often embarrassed about their symptoms and may conceal information to make a good impression (MacKinnon et al. 2006).

Another major difference between medical history taking and psychodynamic interviewing is the interrelationship of diagnosis and treatment. A physician evaluating a patient for appendicitis approaches the interview with a clear mind-set—diagnosis precedes treatment. In the psychodynamic interview, however, any distinction between diagnosis and treatment would be artificial (MacKinnon et al. 2006). The dynamic psychiatrist approaches the interview with the understanding that the manner in which the history is taken may in and of itself be therapeutic. The dynamic view, which inti-
mately links diagnosis and treatment, is empathic in the sense that it takes into account the patient’s perspective. As Menninger et al. (1962) noted: “The patient comes to be treated and everything that is done for him, so far as he is concerned, is treatment, whatever the doctor may call it. In a sense, therefore, treatment always precedes diagnosis” (p. 3). Indeed, there is undoubtedly some therapeutic action in listening and accepting the patient’s life story and validating that the patient’s life has meaning and value (Gabbard 2010). The clinician evaluating a patient is also serving as a witness who is recognizing and grasping the emotional impact of what has happened to the patient (Poland 2000).

A third distinction between medical and psychodynamic interviewing lies in the dimensions of activity and passivity. To a large extent patients are passive participants in the medical diagnostic process. The patient complies with the physician’s evaluation by cooperatively answering questions. The physician, however, must fit together the pieces of the diagnostic puzzle to arrive at a definitive diagnosis. The dynamic psychiatrist tries to avoid this division of roles. Instead, the dynamic approach involves actively engaging the patient as a collaborator in an exploratory process (Shevrin and Shectman 1973). The patient is viewed as someone with a great deal to contribute to the ultimate diagnostic understanding. If a patient begins an interview with anxiety, the psychiatrist does not try to eliminate it to facilitate the interview. On the contrary, the psychiatrist might attempt to engage the patient in a collaborative search for the origins of the anxiety with such questions as: “What concerns about this interview might cause you to be anxious right now?” “Does this situation remind you of any similar anxiety-provoking situations in the past?” or “Have you heard anything about me or about psychiatrists in general that might contribute to your anxiety?”

In a productive dynamic interview, the psychiatrist will elicit information regarding symptoms and history that allows for a descriptive diagnosis. To promote more openness on the part of the patient, however, psychiatrists must guard against an overemphasis on diagnostic labeling that precludes the unfolding of the complex relationship between doctor and patient. Mackinnon et al. (2006) warned that “the interview that is oriented only toward establishing a diagnosis gives the patient the feeling that he is a specimen of pathology being examined, and therefore actually inhibits him from revealing his problems” (p. 6).

A fourth difference between the medical and the dynamic orientation in clinical interviewing revolves around the selection of relevant data. Reiser (1988) expressed alarm at the tendency of some psychiatric residents to stop data collection after eliciting a symptom inventory that satisfies a descriptive diagnostic category and that allows for pharmacotherapeutic prescription. He warned that a DSM diagnosis is only one aspect of the diagnostic process
and that the residents’ lack of interest in understanding the patient as a person forms an obstacle to establishing a therapeutic relationship. For dynamic psychiatrists, the intrapsychic life of the patient is a crucial part of the data pool.

Another unique aspect of the psychodynamic interview is the emphasis on the doctor's feelings during the process. The surgeon or internist who notes feelings of anger, envy, lust, sadness, hatred, or admiration views these feelings as annoyances that interfere with evaluating the illness. The typical physician suppresses these feelings in the service of maintaining objectivity and proceeding with the examination. For the dynamic psychiatrist, such feelings constitute crucial diagnostic information. They tell the clinician something about what reactions the patient elicits in others. These considerations lead us directly to two of the most important aspects of the psychodynamic assessment—transference and countertransference.

The final difference between medical history taking and psychodynamic interviewing is one of pace. In the typical medical interview, the physician is attempting to obtain as much information as quickly as possible to make a decision on diagnosis and treatment and to move on to the next patient in the waiting room. The psychodynamic interviewer, however, should not feel rushed. Psychodynamic clinicians slow things down to create a climate in which the patient can reflect, pause, feel whatever he or she is feeling, and put things together (Peebles 2012). This approach to time conveys a powerful message to the patient: everything will not be understood in one meeting but will ultimately unfold over a period of time. The psychiatric resident may have learned history taking in an emergency department or an inpatient unit where the pace is entirely different. It may take a period of adjustment before residents recognize that they cannot possibly obtain all the information they need for a thorough psychodynamic understanding of the patient. They will simply develop a notion of the key themes that haunt the patient and that have led the patient to come for help. These initial themes may change shape in some ways over time, but they provide a place to start.

Transference and Countertransference

Given the fact that transference is active in every significant relationship, you can be certain that transference elements exist from the first encounter between doctor and patient. Indeed, transference may even develop before the initial contact (Thoma and Kächele 1987). After making the first appointment, the soon-to-be patient may begin attributing qualities to the psychiatrist based on bits of factual information, previous experiences with psychiatrists, media portrayals of psychiatrists, positive or negative experiences with other physicians in the past, or general attitudes toward authority
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figures. One young man who first met his psychiatrist in the waiting room exclaimed, “Why, you’re not at all like I expected you to be!” When the psychiatrist asked the patient to elaborate, the young man explained that the psychiatrist’s name evoked images of a distinguished elderly man, and he was shocked at the youth of the actual psychiatrist.

Transference is a critical dimension of the evaluation because it profoundly affects the patient’s cooperation with the doctor. Patients who view doctors as stern, disapproving parents, for example, will be much less forthcoming with embarrassing aspects of their history. Likewise, patients who view psychiatrists as intrusive busybodies may stubbornly withhold information and refuse to cooperate in the interview. Psychiatrists who address the transference distortions early in the interview may remove obstacles to effective history taking.

During the first few minutes of a consultation with a psychiatrist, one patient was struggling to overcome his inhibitions about talking. The psychiatrist asked if any of his actions or comments made it difficult for the patient to talk. The patient confided that he had harbored the notion that psychiatrists were like mind readers and that he needed to be wary of what he said or did in their presence. The psychiatrist replied humorously, “I’m afraid we’re not that good.” Both laughed, and the patient found it much easier to open up during the rest of the interview.

By definition, transference is a repetition. The feelings associated with a figure from the past are being repeated with the psychiatrist in the present situation. This premise implies that transference patterns in a clinical interview provide glimpses of significant relationships from the patient’s past. The patient’s view of the examiner and the patient’s feelings toward the examiner are somehow repetitions. Furthermore, these repetitions also reveal a good deal about the patient’s current significant relationships. Because transference is ubiquitous, the same patterns from the past are repeated again and again in all the patient’s relationships. For example, a woman patient came to a psychiatrist and complained that men seemed uninterested in her. In response to her psychiatrist’s inquiries, she was able to link this feeling of being neglected with her childhood perception that her father ignored her. When the psychiatrist looked at his clock late in the interview, she accused him of not paying attention to her—just like all other men.

To keep from labeling all the patient’s reactions to the doctor as transference, psychiatrists must keep in mind that the patient–doctor relationship is always a mixture of transference and a real relationship. The psychiatrist who glanced at his clock provided a kernel of reality to the patient’s transference fear that yet another man was losing interest in her. Psychodynamic assessment requires continuous self-monitoring throughout the diagnostic process. The psychiatrist accused of being inattentive must question
whether he really is feeling boredom (and conveying it to the patient) or whether the patient is distorting the situation. If boredom is the problem, then the psychiatrist needs to determine whether his interest is waning because of interference from his own issues, or because the patient is doing something to evoke inattentiveness, or both.

These considerations are, of course, countertransference concerns. The conceptual framework of the dynamic interview is that it involves two persons (dare I say two patients?). Each brings a personal past into the present and projects aspects of internal self and object representations onto the other (Langs 1976). It is commonplace for dynamic psychiatrists to find themselves relating to a patient as though the patient were someone else. The psychiatrist might note a striking physical resemblance between a patient and someone from the past. As a result, the psychiatrist then attributes qualities of the past figure to the patient.

An ongoing task for dynamic psychiatrists is to monitor their own countertransference enactments and feelings as they emerge in the interview with the patient. How much of the countertransference is the clinician's own contribution? How much is induced by the patient's behavior toward the clinician? As I noted in Chapter 2, ordinarily countertransference is a joint creation that involves contributions from both members of the dyad. Making the distinction between the induced variety of countertransference and that brought to the situation by the clinician's own unconscious conflicts is often a challenging task. Because the ability to make this distinction depends greatly on familiarity with one's own internal world, most dynamic psychiatrists find a personal treatment experience (either psychoanalysis or psychotherapy) of enormous value in monitoring and understanding countertransference.

Familiarity with one's own typical responses is helpful in sorting out the relative contributions. One child psychiatrist, for example, observed that she could tell when she was dealing with a victim of child abuse because she would develop an irrational feeling of anger accompanied by an impulse to abuse the child. In other words, an internal abusing object in the child was projected onto the psychiatrist, who in turn became provoked by the child's obnoxious and provocative behavior to the point where she identified with what had been projected onto her. Awareness of those feelings helped her to understand the nature of the patient's internal object world and the typical problems in the patient's interpersonal relationships.

A common form of countertransference that may go unidentified is related to unconscious or conscious assumptions about the patient's race or ethnicity. All clinicians, no matter how committed they are to practicing in a bias-free atmosphere, live and work in societies where racial and ethnic stereotypes abound. These stereotypes may creep into a clinician's diagnostic understanding and may manifest themselves in subtle forms of enactments.
with the patient (Leary 2000). For example, a psychiatric resident found herself speaking more slowly and using simple language with an Asian American patient until the patient interrupted her and said politely, “You don’t have to speak so slowly. I was born here.” Caucasian clinicians may also fail to appreciate the impact on identity and self-esteem that a lifetime of discriminatory practices inflict on a member of an ethnic minority group. Socially induced traumas may be mistakenly understood as problems of a purely intrapsychic nature. Moreover, “white privilege” may make white clinicians oblivious to the powerful impact of seemingly small slights, often referred to as microtraumas, in members of minority groups (Gabbard et al. 2012).

Approaches to History Taking

The history-taking aspect of the interview should involve two simultaneous goals: a descriptive diagnosis and a dynamic diagnosis. To accomplish these goals, the psychiatrist must maintain a flexible interviewing style that shifts from a structured pursuit of specific facts (e.g., about symptoms, family history, stressors, duration of illness) to an unstructured posture of listening to the natural ebb and flow of the patient’s thought processes. Throughout both structured and unstructured portions of the history taking, the examiner makes a fine-tuned assessment of the patient–doctor interaction. Kernberg (1984) characterized one form of the dynamic interview—the structural interview—as a systematic movement from a symptom inventory to an active focus on defensive operations in the here-and-now relationship with the interviewer.

Initially the interviewer must simply create an atmosphere in which the patient feels free to talk. Beginning psychiatric residents commonly err in aggressively interrogating patients only to elicit history and symptoms. Another common error is the assumption of a pseudoanalytic attitude of abstinence, virtual silence, and passivity. Residents who may be warm and personable individuals suddenly become stiff, overly formal, and cold when they interview a patient. The interviewer will get much further by becoming an active participant in the relationship—by warmly and empathically seeking to understand the patient’s point of view.

The psychiatrist can learn a great deal by allowing the patient to ramble freely for a while. Initial comments should be designed to facilitate this rambling (e.g., “Tell me more,” “Please go on,” “I can understand your feeling that way,” or “That must have been upsetting”). The distinctiveness of the material produced by this type of free association is supported by evidence from neuroscience research. Andreasen et al. (1995) used positron emission tomography to study the difference between focused episodic memory, when one recalls past experiences, and random episodic memory, involving uncensored thinking about experience, akin to free association. They found
significant differences between the two types of memory and noted that the free-ranging mental activity associated with random episodic memory produced large activations in association cortex and reflected both active retrieval of past experiences and planning of future experiences. Hence the alternation between allowing rambling associations in the interview and focusing the patient on specific events may produce different kinds of mental activity and different types of useful information for the interviewer.

Besides eliciting essential historical and mental status data, interviewers can discern patterns of association that may reveal significant unconscious connections. The order in which events, memories, concerns, and other psychological issues are verbalized is seldom random. Mathematicians have long known that it is impossible for any individual to generate prolonged sequences of random numbers. Within a short time, the numbers will fall into meaningful patterns. The mind prefers order to chaos. So it is with the verbalizations of the patient. Deutsch and Murphy (1955) based their approach to interviewing—known as “associative anamnesis”—on this principle:

The method...consists in recording not only what the patient said, but also how he gave the information. It is of consequence not only that the patient tells his complaints, but also in what phase of the interview, and in which connection he introduces his ideas, complaints, and recollections of his somatic and emotional disturbances. (p. 19)

Although patients may be consciously baffled by their symptoms, the ordering of their associations may provide clues to unconscious connections. For example, a 31-year-old man who came with his parents for a psychiatric evaluation began the morning with a psychiatrist while his parents met privately with a social worker in a different building. The young man began by explaining that he had been unable to keep a job. He suddenly became overwhelmed with anxiety because he was uncertain of his parents’ whereabouts. The psychiatrist clarified that they were with the social worker in the office building next door. The patient asked if he could use the psychiatrist’s phone to call them. The psychiatrist silently noted that the patient’s anxiety about his parents’ location followed immediately on the heels of his complaint of not being able to hold a job. He asked the patient if the two concerns were connected. After a moment’s reflection, the patient acknowledged that when he was away from his parents, at work, he worried that something would happen to them. This interchange led to a productive discussion about the patient’s concerns that his growing up and becoming independent would be destructive to his parents.

Because of the central role of developmental theory in dynamic psychiatry, a developmental history must be part of a thorough dynamic assessment. Was the patient a product of an unwanted pregnancy? Did the patient’s birth
occur after an older sibling had died? Did the patient achieve developmental milestones such as talking, walking, and sitting up at the appropriate ages? Were there traumatic separations or losses during the formative years? Obtaining such invaluable information often necessitates interviews of parents and other family members—either by the psychiatrist or by a social worker associated with the psychiatrist. Obviously, patients will be unable to recall some significant events of childhood and will distort others.

Despite their imperfect memories for historical events, patients should nevertheless be engaged in a review of childhood and adolescent development. A fundamental principle of the dynamic interview is that the past is repeating itself in the present. To enlist the patient as a collaborator in the diagnostic process, the interviewer can encourage the patient’s curiosity about links between historical events and present-day feelings. A variety of open-ended questions serve to establish this collaborative partnership: “Does the anxiety you’re experiencing today remind you of feelings you’ve had at any time in your past?” “Were there any events in your childhood that may have contributed to your feeling as an adult that women cannot be trusted?” “Do your current marital problems have any similarities with problems you’ve had in other relationships in the past?” As the patient begins to collaborate in the search for links between past and present, the examiner should note particular historical events and periods that seem important to the patient. Similarly, conspicuous omissions from the developmental history are also noteworthy. Does the patient, for example, focus exclusively on one parent as the cause of all current problems while omitting any reference to the other parent? What about the patient’s cultural and religious background? How do these factors affect family relationships and the acceptability of emotional problems?

After several minutes of open-ended questions designed to facilitate a free-flowing history of the present illness and family and developmental issues, the psychiatrist can then fill in the gaps with more specific, direct questions. These may be geared to the descriptive diagnosis (e.g., specific symptoms necessary for the DSM-5 [American Psychiatric Association 2013] diagnosis, information about the duration of the illness, exclusions of other illnesses) or may be directed toward a more complete dynamic diagnosis (e.g., specific developmental traumas, relationship patterns, or recurrent fantasies and daydreams). As the patient fills in the gaps, the dynamic psychiatrist can begin to formulate hypotheses that link the patient’s past relationships with current relationships and with emerging transference paradigms (Menninger 1958). In other words, how are repetitions of past relationship patterns creating problems in the present?

Patients can provide important dynamic information about their perception of the connections between events and symptoms. Again the examiner
should think in terms of how issues from the past are evoked by stressors in the present. One female executive developed extraordinary anxiety after receiving a promotion. She identified the promotion as the stressor but could not determine why it provoked anxiety, because she had sought the new job for several years. In the course of the interview, she frequently referred to her younger sister, who was divorced and supporting two children through a menial job. Further exploration of intense sibling rivalry that had existed between the sisters during childhood revealed that the executive’s anxiety was related to guilt feelings. She was convinced that her promotion had been destructive to her sister. These feelings resonated with her childhood wish to triumph over her sister and be the only child in the eyes of their parents.

Holmes and Rahe (1967) developed a scale that ranks the severity of stress in a number of different life events. Although such scales can help provide consensual estimates of the effects that accompany particular life events, the dynamic psychiatrist must approach each patient as a unique individual and not assume a priori that a certain life event has only one specific meaning. For example, one young man reacted to his father’s death with a liberated sense that he was finally free to pursue his career without incessant criticism. Hence, the stressor resulted in improved school performance and enhanced overall functioning.

In addition, the examiner should keep in mind that some stressors may operate at an unconscious level, preventing the patient from identifying any precipitating event when asked to do so. One function of the interview may be to work together to determine whether any stressors have been overlooked. Anniversary reactions, for example, are common stressors the patient may neglect. One chronically depressed patient became acutely suicidal on the anniversary of her brother’s suicide. In another instance, when a happily married physician began having marital problems for no apparent reason, he called on a psychiatric colleague for advice. During the course of their phone conversation, the doctor suddenly realized that he was calling on the tenth anniversary of his divorce from his previous wife. This insight revealed that his current anger at his present wife was partially linked to his stormy relationship with his first wife.

Mental Status Examination

Like descriptive psychiatrists, dynamic psychiatrists are interested in mental status data, but they approach the information somewhat differently. First, to the extent that it is reasonable and possible, they prefer to weave mental status questions into the fabric of the interview rather than to add them at the end in a list of formal mental status questions (MacKinnon et al. 2006). Although some specific mental status questions should obviously be ap-
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Pended to the interview if they are not elicited during it, there is an advantage in minimizing the formal mental status examination. When these questions are brought into the body of the interview, the patient views distortions of perception, thought, and affect in a meaningful context. Moreover, in determining connections between such distortions and the illness, the patient becomes more involved as a collaborator rather than as merely a passive responder to questions.

Orientation and Perception

A patient's orientation to time, place, and person is often clear in the course of history taking. To ask specific orientation questions of someone who is obviously well oriented is likely to disturb the rapport of the doctor–patient relationship. Hyperalertness is a mental status finding that will also reveal itself without direct questioning. Significant perceptual symptoms such as auditory or visual hallucinations will often be evident at the beginning of the interview when the patient is asked to explain why psychiatric treatment is being sought. However, the dynamic psychiatrist is interested in more than the presence or absence of hallucinations. If a patient hears voices, the psychiatrist wants to know what the voices say, under what circumstances they speak, whose voices they sound like, and what the voices mean to the patient.

Cognition

The presence of a formal thought disorder will usually be clear from the history-taking portion of the interview. As alluded to earlier, even loose associations are connected idiosyncratically in the patient's mind. The examiner's task is to understand the nature of such connections. Delusions are also more likely to be elicited by open-ended historical questions than by specific questions about "false beliefs." The presence or absence of delusions is only part of the psychodynamic assessment; their meanings and functions are equally relevant. The grandiose delusions of the paranoid patient may serve to compensate for devastating feelings of low self-esteem.

Because cognition affects language and communication, the psychiatrist must also listen for parapraxes, or slips of the tongue, that reveal glimpses of the unconscious at work. A pregnant woman whose obstetrician referred her for a psychiatric consultation was resentful about seeing a psychiatrist, and at one point she exclaimed, "I don't want to be a psychiatric parent—I mean patient!" The examining psychiatrist could conclude from this parapraxis that the patient was highly ambivalent about becoming a mother.

The patient's manner of answering questions may reveal a good deal about his or her unconscious character style. The obsessive-compulsive patient may respond to questions with an overinclusive attention to detail,
frequently asking the examiner to elaborate on specifically requested information. By contrast, the passive-aggressive patient may produce anger in the interviewer by asking for questions to be repeated and by generally thwarting attempts to elicit historical data. The paranoid patient may constantly read hidden meanings into the questions, thus placing the examiner on the defensive.

Determining the presence or absence of suicidal ideation is essential to any psychiatric evaluation. Suicidal patients should be asked outright if they have a suicide plan and if they have a support system of people they can talk to before acting impulsively. The psychodynamic assessment should discern the meaning of the contemplated suicide. Is there a reunion fantasy with a deceased loved one? Is suicide a vengeful act designed to devastate someone else just as that person once devastated the patient? Is suicide really designed to kill an internal object representation that is hated and feared? Of the many possible solutions to a patient's problems, why is suicide so compelling?

**Affect**

Observations about the patient's emotional states provide a gold mine of information about defense mechanisms. After all, the management of affect is one of the most important functions of defenses. Patients who describe extraordinarily painful events in their lives without being moved in the least may be employing isolation of affect. Hypomanic patients who assert that they always are in a good mood and are unusually jocular with the examiner may be using denial to defend against feelings such as grief and anger. Borderline patients who express contempt and hostility toward the key figures in their lives may be employing splitting to ward off any integration of good and bad feelings toward others. Mood, a subcategory of affect involving a sustained, internal feeling tone, should also be assessed. Exploration of moods with a patient often reveals that they are linked with significant self and object representations.

**Action**

A wealth of information is communicated through nonverbal behavior in the clinical interview. What particularly sensitive subjects result in the patient's fidgeting? What topics evoke silence? What issues cause the patient to break off eye contact with the examiner? Despite the fact that patients attempt to conceal essential data from the examining psychiatrist, their nonverbal behaviors will consistently betray them. Freud made the following observation in 1905:

> When I set myself the task of bringing to light what human beings keep hidden within them, not by the compelling power of hypnosis, but by observing
what they say and what they show, I thought the task was a harder one than it really is. He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore. And thus the task of making conscious the most hidden recesses of the mind is one which it is quite possible to accomplish. (Freud 1905/1953, pp. 77–78)

As Freud implied, one of the “royal roads” to the observation of the unconscious is nonverbal behavior. Freud’s observation has been systematized in the work of Paul Ekman (1985), who developed the Facial Action Coding System that categorizes some 10,000 facial expressions. Ekman learned that facial expressions were hard-wired into the brain and can erupt without any conscious awareness about 200 milliseconds after a stimulus. He was able to identify when someone was telling a lie by studying the microexpressions that lasted less than half a second as the person responded to questions. He also noted that hand movements, posture, speech patterns, and “distancing language” are also characteristic of lying. Although an ordinary psychodynamic interview is not in a forensic setting, in which determining truthfulness is essential, Ekman’s findings alert all clinicians to study subtle shifts in facial expression, body posture, and style of speaking as a sign of important emotional themes that the patient wishes to conceal. Early attachment relationships are internalized and encoded as implicit memory (Amini et al. 1996; Gabbard 1997). What unfolds in the relationship to the therapist is the patient’s habitual mode of object relatedness shaped by those early attachment relationships, and much of that mode of relatedness is nonverbal. Patients who, for example, are shy about making eye contact, deferential in their manner, restrictive in their uses of gesture, and hesitant in their speech patterns are telling the clinician a great deal about their unconscious, internalized object relations and the way they relate to others outside of the clinical interview.

Psychological Testing

Projective psychological tests, principally the Rorschach and the Thematic Apperception Test, may be extraordinarily useful adjuncts to the psychodynamic assessment. The Rorschach consists of 10 symmetrical inkbLOTS that present ambiguous stimuli to the patient. In the face of this ambiguity, patients will reveal a great deal about themselves through their interpretations of the amorphous shapes within the inkbLOTS. Highly sophisticated guides to Rorschach interpretations have systematized the responses according to a psychodynamic diagnostic understanding of the patient (Kwawer et al. 1980; Rapaport et al. 1968; Schafer 1954).

The Thematic Apperception Test operates on a similar principle. A series of drawings or woodcuts, portraying persons and situations of varying de-
degrees of ambiguity, allows patients a good deal of latitude in interpretation. Patients are asked to invent a story to describe each picture. In making up these stories, patients project their own fantasies, wishes, and conflicts onto the pictures. Projective testing is especially useful for patients who are guarded and laconic in the psychiatric interview and therefore do not share their inner life freely with the psychiatrist. Many patients, however, will reveal so much about themselves in the course of the clinical interview that psychological testing is not necessary as an adjunct.

In addition to projective testing, standard psychological tests that measure personality traits may be of considerable usefulness as well. The Millon Clinical Multiaxial Inventory (Millon 1977), for example, now in its third iteration, is useful for identifying characteristic themes in the patient’s personality that may reflect wishes, fears, and defenses.

Physical and Neurological Examination

For obvious reasons, the patient’s physical and neurological status is as important to the dynamic psychiatrist as it is to the descriptive psychiatrist. “The head bone is connected to the neck bone,” so whatever goes wrong in the body will affect the brain—and vice versa. If the assessment is taking place in a hospital setting, dynamic psychiatrists may or may not perform their own physical and neurological examinations. If the assessment is of an outpatient in a private office, most dynamic psychiatrists prefer that an internist or other physician do the physical. Regardless of who does it, exploring the meaning of the physical is usually beneficial—both in terms of transference issues and in terms of patients’ fantasies about their body. In any case, neither a descriptive nor a dynamic assessment can be complete without these data.

Psychodynamic Diagnosis

At the completion of the psychodynamic assessment, the clinician should arrive at a descriptive diagnosis (based on DSM-5 criteria) and a psychodynamic diagnosis (based on an understanding of the patient and the illness). Although both diagnoses inform the treatment planning, the descriptive diagnosis is geared to the assignment of the correct label, whereas the psychodynamic diagnosis is viewed as a summary of understanding that goes beyond the label.

The descriptive diagnosis may assist clinicians in planning appropriate pharmacological interventions. The dynamic diagnosis may facilitate the cli-
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The psychodynamic assessment of the patient's understanding of what the medication prescription means to the patient and whether compliance with the medication is likely to be a problem. In this context, I want to emphasize that the usefulness of a dynamic diagnosis is not limited to patients whose prescribed treatment is dynamic psychotherapy. The therapeutic management of the patient's personality is an integral part of all psychiatric treatment that must always be considered in treatment planning (Perry et al. 1987).

A complete psychodynamic diagnosis also involves assessing the patient from one or more of the four major theoretical perspectives discussed in Chapter 2: ego psychology, object relations theory, self psychology, and attachment theory. There is a clear advantage for the psychodynamic interviewer to think about multiple theoretical models as the material in the session unfolds. When clinicians draw on multiple perspectives rather than a favored one or two, the patient is likely to benefit because richer and more complex treatment planning can be designed with the different models in mind (Peebles 2012). Moreover, within psychoanalytic and psychodynamic thinking today, pluralism is far more common, as we have learned that one theoretical system rarely has all the answers for all patients.

Characteristics of the Ego

A great deal can be learned about patients’ overall ego strength from their work histories and their relationship patterns. Those who have been able to hold jobs and establish committed relationships for reasonably long periods are likely to have more resilient egos than those who have not.

The assessment of certain key ego functions (Bellak et al. 1973) can help psychiatrists understand a patient’s strengths and weaknesses and thus enable them to prescribe the treatment program. How is the patient’s reality testing? Is there an ability to distinguish what is internal from what is external, or is there a persistent pattern of delusional misperception? Is the patient’s reality testing intact in structured situations but impaired in unstructured situations? What about the patient’s impulse control? Is there sufficient ego to delay the discharge of impulses, or is the patient virtually driven by impulses to the point where there is danger to others or self? Judgment is another ego function that must be assessed. Can the patient adequately anticipate the consequences of actions?

In planning for the appropriate form of psychotherapy, psychiatrists should also determine the psychological mindedness of the patient. Does the patient see problems as having an internal origin, or are all difficulties externalized and blamed on others in the environment? Can the patient synthesize and integrate various bits of data and reflect on their connections to develop meaningful explanations for symptoms and interpersonal difficul-
ties? Does the patient think in metaphors and analogies that allow for connections between various levels of abstraction? All these considerations aid in assessing the extent of psychological mindedness.

A major portion of ego assessment focuses on the defensive functioning of the ego. In the psychoanalytic setting, Waelder (1960) developed a series of questions that addresses the defensive operations of the patient. These same questions could be adapted to the dynamic assessment: “What are the patient's desires? What does the patient (unconsciously) want? And of what is he afraid? …And when he is afraid, what does he do?” (pp. 182–183). Pine (1990) added additional questions to assess the relationship between drives and the ego's responses to the drives:

> What wish is being expressed? what is the relation of the wish to consciousness? what is the fantasy? and how does it reflect a compromise among wish and defense and reality? how was the wish being defended against? and how effective/adaptive is the defense? can the particular anxiety seen be traced to this or that wish, ineffectively defended against? and can the particular guilt seen be understood in terms of the operation of conscience in relation to this or that wish? (pp. 44–45)

Pine also suggested that one should assess character in a similar manner by looking at the patient's characteristic defensive styles that are expressed as ego-syntonic modes of function. One can also assess the defense mechanisms on the continuum of immaturity to maturity described in Chapter 2. The patient who is able to use suppression and humor in the midst of a difficult situation is showing much greater ego strength than the patient who resorts to splitting and projective identification in the same situation.

Determining the ego's relationship to the superego is another vital part of an ego psychological assessment. Is the superego a rigid and ruthless overseer of the ego, or is there a flexibility and harmony in the relationship of superego to ego? Does the patient espouse realistic ideals, or is the patient driven by unreachable and fantastic goals? Are there antisocial tendencies in the patient characterized by an absent or underdeveloped superego? The answers to these questions also provide clues about the patient's childhood experiences with parental figures, because the superego is an internalized representation of those figures.

Object Relations

As an end result of the psychodynamic assessment, the clinician has information about the patient's interpersonal relationships in three contexts: childhood relationships, the real and transferential aspects of the relationship between the patient and the examining clinician, and current rela-
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tionships outside the doctor-patient relationship. The nature of these relationships provides the psychiatrist with a good deal of information about the patient's position in family and social systems. Still needed, however, is an assessment of how the patient's family relationships influence the development of the clinical picture that brings the patient to the psychiatrist. Does an adolescent patient's symptomatic picture reflect the parents' marital problems? In other words, is the patient serving as a "carrier" of illness for the entire family?

Information about the patient's interpersonal relationships also tells a great deal about the nature of the patient's internal object relations. Interviews of family members and significant others can help sort out the extent of distortion inherent in the patient's view of other relationships. Certain easily discernible patterns seem to cut across all relationships. For example, does the patient always seem to end up as a masochistic partner in a sadomasochistic bond? Is the patient always taking care of others who are less functional and more in need of caretaking? Pine (1990) developed a series of questions specifically targeted at object relations that can be mulled over by the clinician during the course of an interview:

What old object relationship is being repeated? and which of the roles in the object relationship is the subject (the patient) enacting—his own or that of the other? or both? Is the patient behaving like the person he was? he wished to be in the parents' eyes? they wanted him to be? they were? he wished they were? And what early passive experiences are being repeated actively? (p. 47)

Determining the level of maturity of object relations is an integral part of this assessment. Does the patient experience others ambivalently as whole objects having both good and bad qualities? Alternatively, does the patient view others as either idealized (all good) or devalued (all bad)? Does the patient see others as need-gratifying part-objects who serve only one function for the patient rather than as separate persons with needs and concerns of their own? Finally, what about object constancy? Can the patient tolerate being apart from significant others by summoning up a soothing internal image of the person who is missed?

The Self

A thorough dynamic assessment must evaluate several aspects of the patient's self. In the broad framework of self psychology, psychiatrists should examine the durability and cohesiveness of the self. Is it prone to fragmentation in response to the smallest slight from a friend or colleague? Does the patient need to be in the spotlight continually to receive affirming responses
from selfobjects? The maturity of the patient's selfobjects should also be assessed. Are the patient's selfobject needs satisfied by a mutually gratifying relationship in the context of a long-term commitment?

In addition to self-esteem, the psychiatrist should also assess the patient's self-continuity. Is the patient much the same over time, regardless of external circumstances, or is there a generalized identity diffusion? As Horowitz (1997) stressed, without a sense of self-coherence and continuity, an individual is more likely to develop symptoms and explosive shifts in his or her state of mind. Horowitz also pointed out that self-coherence is more than interpersonal style—it includes integrity and virtues within one's character. Evidence for identity diffusion would indicate that different self representations, split off from one another, are constantly jockeying for dominance over the total personality. Different self representations would obviously arise in connection with different object representations that are highly influenced by the interpersonal context at a given moment. The boundaries of the self are also of interest. Can the patient clearly differentiate his or her own mental contents from those of others, or is there a general blurring of self–object boundaries? Are the patient’s body boundaries intact? Are mind and body viewed as connected over time, or are there episodes of depersonalization or out-of-body experience in which the mind seems independent of the body?

Attachment Patterns and Mentalization

The evaluating clinician listens to patterns of attachment and hopes to understand the patient's internal working models according to familiar categories of adult attachment: 1) secure/autonomous, 2) insecure/dismissing, 3) preoccupied, and 4) unresolved/disorganized (see Chapter 2). In a research setting, interviewers are likely to make use of the Adult Attachment Inventory, which is a semistructured interviewed composed of 15 questions that address the individual's experiences of parents or caregivers during childhood and their influence upon the individual as an adult (Gullestad 2003). In some respects, it is the adult equivalent of the Strange Situation (Stein et al. 1998). This instrument requires extensive training and a scoring manual. In the clinical setting, clinicians must simply listen for patterns and consider how the childhood experiences may contribute to adult relationships. In addition, they can assess to what extent the difficulties in early attachment may have promoted or impaired the capacity to mentalize. When children are securely attached, they develop the ability to understand people in terms of their feelings, desires, beliefs, and expectations (Fonagy 2001). In cases of trauma or neglect, children tend to shut down their thinking and dare not conceive of the parent's or caregiver's mind. This defensive reaction may impair the capacity to mentalize (Fonagy 2001).
Psychodynamic Formulation

The different elements enumerated in the previous discussion are the basis of a psychodynamic formulation. This tentative hypothesis or working model illustrates how the elements interact to create the clinical picture presented by the patient. Psychodynamic formulations must be embedded in a biopsychosocial context (Gabbard 2010). Three components form the foundation of a good formulation (Sperry et al. 1992). The formulation should begin with a sentence or two describing the clinical picture and the associated stressor or stressors precipitating the reason for seeking help. The second part of a formulation is developing a set of hypotheses about how biological, intrapsychic, and sociocultural factors contribute to the clinical picture. The third component is a brief statement about how the first two features of the formulation may inform the treatment and the prognosis.

Several underlying principles should be involved in the construction of a psychodynamic formulation. First, biological factors can be genetic or can be based on environmental influences, such as early trauma or head injury. Second, sociocultural factors may include family, religion, cultural practices, or even the impact of immigration. Some patients will appear more disturbed in a new culture than they might have in their home country. The loss of love objects, cultural values, native language, and original environment may lead to a “culture shock” phenomenon that severely compromises the immigrant’s identity and self-esteem and precipitates a mourning process (Halperin 2004). Although the formulation is intended to explain the patient’s condition, it does not have to explain everything. It should succinctly highlight the major issues, especially their relevance to treatment planning.

With some patients, one theoretical model will appear to have more explanatory value than the other two. With other patients, however, more than one theoretical perspective may seem useful in conceptualizing various aspects of the patient’s psychopathology. As suggested in Chapter 1, clinicians should be open-minded to all the major theoretical frameworks and should embrace a “both/and” rather than an “either/or” attitude. The formulation should also be approached with the understanding that it undergoes continual modification as treatment proceeds. In dynamic psychiatry, diagnosis and treatment are always evolving together. A sample case history illustrates these points:

Ms. A, a 33-year-old single woman employed as a librarian, came to the hospital in the midst of a psychotic episode with paranoid features. She had become convinced that her mother was plotting to kill her, and she had barricaded herself in the apartment she shared with her brother.

When Ms. A reorganized after a few doses of an antipsychotic, she presented herself as a cheerful, Pollyanna-like person, commenting, “I have no
anger in me.” She said she felt fine and wanted to go home. Her mother was glad to see her “back to normal” but expressed concern because Ms. A's brother was still at the apartment. He had apparently exploited his sister by moving in, eating her food, and living rent-free for the past several weeks.

According to her mother, Ms. A lived an isolated existence and had few interpersonal contacts outside several superficial relationships at work. Moreover, the patient's mother revealed that Ms. A had had one previous psychotic episode 18 months earlier when her brother had moved in with her under the same exploitative circumstances. Ms. A's mother also reported a family history of bipolar affective disorder.

The following psychodynamic formulation was developed: Ms. A inherited a diathesis toward bipolar affective disorder. Her cyclic psychotic episodes, which appeared schizophreniform, were possibly a variant of bipolar illness. After stabilizing the psychosis, the psychiatrist could consider prophylaxis with lithium or another mood stabilizer.

When Ms. A is nonpsychotic, her adjustment comes at the expense of massive denial of all negative feelings, especially anger, and results in a schizoid existence. The stressor of having her brother living parasitically in her apartment provoked so much anger in Ms. A that she could not maintain her usual defensive posture. Under pressure of this intense affect, she regressed to the paranoid-schizoid position, where an unacceptable self representation harboring angry, murderous feelings was split off and projected onto her mother. After remission of Ms. A’s psychosis with medication, she reintrojected the self representation, which once again became buried under her denial.

The patient lacks the psychological mindedness to see any problems to work on in an exploratory therapy process. Casework or family therapy is therefore needed to remove the stressor (i.e., the brother) and to allow Ms. A to resume her previous adjustment with a follow-up regimen of medication and supportive psychotherapy to maintain her defenses and identify other potential stressors. We can anticipate further treatment compliance problems if her brother returns.

Although dynamic in its conceptualization, this formulation is in keeping with the biopsychosocial model of psychiatry championed by Engel (1977), Fink (1988), and others in that it takes into account genetic predisposition, social–familial influences, and intrapsychic factors.

**Conclusion**

Table 3–1 summarizes the steps involved in a thorough psychodynamic assessment. In the final analysis, the purpose of the assessment is to inform and guide the overall treatment planning. The case of Ms. A illustrates how a psychodynamic diagnosis, and particularly a psychodynamic formulation, can be useful even when dynamic psychotherapy is contraindicated. The treatment is nevertheless dynamically informed. The dynamic assessment
TABLE 3–1. Psychodynamic assessment

<table>
<thead>
<tr>
<th>Historical data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present illness with attention to associative linkages and stressors</td>
</tr>
<tr>
<td>Past history with emphasis on how the past is repeating itself in the present</td>
</tr>
<tr>
<td>Developmental history</td>
</tr>
<tr>
<td>Family history</td>
</tr>
<tr>
<td>Cultural/religious background</td>
</tr>
</tbody>
</table>

Mental status examination

- Orientation and perception
- Cognition
- Affect
- Action

Projective psychological testing (if necessary)

Physical and neurological examination

Psychodynamic diagnosis

- Descriptive DSM-5 diagnosis
- Characteristics of the ego
  - Strengths and weaknesses
  - Defense mechanisms and conflicts
  - Relationship to superego
- Quality of object relations
  - Family relationships
  - Transference–countertransference patterns
  - Inferences about internal object relations
- Characteristics of the self
  - Self-esteem and self-cohesiveness
  - Self-continuity
  - Self-boundaries
  - Mind–body relationship

Attachment patterns/mentalization capacity

Psychodynamic formulation using above data

assists all aspects of treatment planning. An evaluation of ego functions can contribute to a decision regarding whether an individual should be an inpatient or an outpatient. For example, the extent of impulse control may be a crucial variable in deciding whether a patient should be admitted in the first place and, if so, when the patient can be discharged. A dynamic understanding of their patients can help clinicians decide whether their patients would accept a recommendation for sex therapy, behavior modification, family
therapy, or group therapy. Finally, each patient's compliance with any medication regimen will be affected by that particular patient's characterological substrate. The cases discussed in subsequent chapters illustrate how other theoretical models can be used in developing a formulation and how the dynamic assessment of the patient guides the treatment planning.

References


Fink PJ: Response to the presidential address: is “biopsychosocial” the psychiatric shibboleth? Am J Psychiatry 145:1061–1067, 1988


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Langs RJ: The Bipersonal Field. New York, Jason Aronson, 1976